Wisconsin Medicaid Program

Outpatient Hospital State Plan

Attachment 4.19-B

Methods and Standards For Determining Payment Rates

With Amendments Effective July 1, 2004

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1000 OVERVIEW

This section is an overview of how the Wisconsin Medicaid program (WMP) establishes payment rates for hospital outpatient care provided persons eligible for fee-for-service coverage under the WMP. The payment is for outpatient medical services provided by a hospital in its licensed facility, for which the patient does not need to be admitted for an overnight stay, and for which the WMP does not pay another certified Medicaid provider. Payment rates are hospital-specific, cost-based and annually adjusted to recognize that hospitals vary significantly in the types of medical services they provide.

Hospitals located in the State of Wisconsin are reimbursed for outpatient services at an interim rate per visit with a subsequent retrospective final settlement as described in section 4000. The settlement takes into account the costs incurred by the hospital during its cost-reporting period, which generally is the hospital's fiscal year. Reimbursed costs under the retrospective settlement are limited to a prospectively established ceiling amount. The ceiling amount is a prospective, hospital-specific rate per outpatient visit that is based on a hospital's historical cost and adjusted to stay within the State's available funding for outpatient hospital services. Critical access hospitals are exempt from the ceiling rate.

Ceiling rates are recalculated annually for the upcoming State fiscal year effective July 1 based on an audited cost report for each hospital. Administrative adjustment for the ceiling are available to recognize certain changes in costs incurred by the hospital that are not reflected in the historical cost report period (§6000). Payments for outpatient hospital laboratory tests are limited to the WMP's fee schedule for laboratory tests.

For hospitals not located in the State, reimbursement is at a percentage of charges (§5000). No final cost settlement is done for these hospitals. Under §5700, a prospective outpatient payment is provided for approved respiratory nursing care for part of a day on the site of an acute care general hospital. Payment for this service is separate from and not covered by the final cost settlements.

2000 STATUTORY BASIS

The outpatient reimbursement shall comply with all current and future applicable Federal and State laws and regulations and shall reflect all adjustments allowed under said laws and regulations. Federal regulations (42 CFR §447.321) require the Medicaid agency not pay more for outpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

3000 GENERAL ITEMS

Hospital Facility. A *hospital facility* is the physical entity, surveyed and licensed by the Wisconsin Department of Health and Social Services under Chapter 150, Wis. Stats. For hospitals not located in Wisconsin, a hospital facility is the physical entity that is covered by surveying, licensure, certification, accreditation or such comparable regulatory activities of the state in which the hospital is located.

Hospital Licensure of Provider Premise. Only medically necessary covered services provided within the physical licensed premises of a licensed *hospital facility* are eligible for reimbursement under outpatient hospital payment rates described in this document entitled "Methods and Standards for Determining Outpatient Hospital Payment Rates". This means a hospital cannot bill as outpatient hospital services those services provided off the physical premise of the licensed hospital facility or in an unlicensed portion of the hospital facility.

Outpatient Visit. An admission to the outpatient hospital on a given calendar day, regardless of the number of procedures or examinations performed or departments visited. A maximum of one outpatient visit per patient per calendar day shall be recognized and paid.

Cost Reporting. Each hospital participating in the Wisconsin Medicaid program (WMP) shall prepare a Title XIX cost report at the close of its fiscal year. In-state hospital providers must submit the cost report and accompanying supplemental schedules to the Department's audit intermediary by the date required by Medicare for submission of the cost report. If a provider is granted an extension for Medicare, the WMP will automatically extend its deadline.

Clinical Diagnostic Laboratory Reimbursement. The lower of laboratory fee schedule amounts of the Wisconsin Medicaid program or the hospital's laboratory charges for services provided.

Upcoming State Fiscal Year. The upcoming state fiscal year is the fiscal year of the State of Wisconsin that begins each July 1 for which prospective outpatient rates are calculated under section 4200.

Critical Access Hospital. A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS (HCFA), and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

4000 REIMBURSEMENT OF OUTPATIENT SERVICES OF IN-STATE HOSPITAL PROVIDERS FOR OUTPATIENT VISITS ON AND AFTER JULY 1, 2001

4100 Introduction. This section 4000 describes the methodology for reimbursing hospitals located in the State of Wisconsin for outpatient hospital services provided persons eligible for fee-for-service medical coverage by the Wisconsin Medicaid program (WMP). The methodology described in §4200 through §4400 applies for outpatient visits occurring on and after July 1, 2001. Special provisions for the reimbursement of critical access hospitals are described in §4900 also effective July 1, 2001. An example of the calculation of a hospital's rate per outpaient visit is in the Appendix, page 13.

4200 Establishing a Hospital-Specific Rate per Outpatient Visit

4205 Cost Report Used and Base Year. A hospital's rate per outpatient visit is based on a hospital's historical cost of a recent fiscal period. Cost is identified from the most recently completed cost reporting period of at least six months for which the Department has an audited cost report on file as of April 30 prior to the beginning of the upcoming State fiscal year. The Department may at its option use an audited cost report it receives at a later if the end date of the cost report on file precedes the beginning of the upcoming State fiscal year by more than three years, three months. For example, for the State fiscal year beginning July 1, 2001, a cost report received after April 30, 2001 may be used if the end date of the cost report period on file is prior to April 1, 1998, (calculated by taking July 1, 2001 minus 3 years, 3 months).

For newly established hospitals for whom an audited cost report is not available, the Department will designate a cost report to be used that may be a cost report that is received after the above April 30th date. It may be the audited cost report for the first retrospective settlement period of the new hospital that is six months or longer.

A new owner may take-over the operation of a hospital. Cost reports from the prior owner of the hospital are used to establish the prospective rate per outpatient visit until an audited cost report becomes available under the new ownership. Separate hospitals may combine into one operation, under one WMP provider certification, either through merger or consolidation or through a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospitals physical plant. The audited cost reports of the separate hospitals are combined to establish the prospective rate per outpatient visit for the combined hospital provider until an audited cost report is available for the combined operation.

It should be noted that the audited cost report is the basis for calculating the rate per outpatient visit of §4220. The same audited cost report is used for the retrospective settlement period process described in §4410. For the administrative adjustment criteria of §6000 and §6800, the terms "o*utpatient base year*" and *"base year"* refer to the cost report period described above even if the period is more or less than a year.

4210 Calculate Average Inflated Cost per Visit. An average inflated cost per visit is established from the audited cost report of each hospital. The cost report includes a methodology of cost finding that identifies the amount of costs applicable to outpatient services provided persons covered by the WMP. This cost is inflated to the upcoming State fiscal year by an inflation adjustment multiplier. The resulting inflated cost divided by the number of WMP outpatient visits incurred by the hospital during the cost report period results in the hospital's *"average inflated cost per visit".*

Inflation adjustment multipliers result from the following ratio calculation: price index for the ending quarter of the upcoming State fiscal year divided by the price index for the ending quarter of the audited cost report of each hospital. The indexes used are from the publication, "Health Care Cost Review", that is published quarterly by theDRI•WEFA, Inc., a Global Insight Company . (Prior to the second quarter of 2001, the "Health Care Cost Review" was published quarterly by the Standard & Poor's DRI division of The McGraw-Hill Companies.) Specifically used are the total market basket indexes as listed by calendar quarter in the tables for HCFA's hospital prospective reimbursement. In the publication's second quarter 2000 edition, this table is entitled "HCFA Hospital Reimbursement Market Based (PPS) – Historical Data" for historical quarters and, for forecasted future quarters, the table is entitled "HCFA Hospital Prospective Reimbursement Market Basket (PPS) – Quarterly Forecasts".

4220 Calculate Rate per Outpatient Visit. A prospective *"rate per outpatient visit"* is calculated for each hospital for the period of each upcoming State fiscal year beginning July 1. The average inflated cost per visit is multiplied by a budget neutrality factor. The budget neutrality factor is a percentage applied to costs in order to maintain payments within the federal upper payment limits of 42 CFR §447.321 and the State's available funding for outpatient hospital services for the upcoming State fiscal year. The resulting *"rate per outpatient visit"* is a limit or ceiling on the costs to be reimbursed in the retrospective settlement that will be done in subsequent years when the hospital's audited cost report for its present in-process fiscal period becomes available to the Department.

4240 Hold-Harmless Rate per Visit. A hospital's *"hold-harmless rate per visit"* is the amount that the WMP paid, or would pay, the hospital on June 30, 2001 for an outpatient visit occurring on June 30, 2001. Subsequent retroactive administrative adjustments and retroactive final settlement adjustments to this June 30, 2001 rate of payment are not recognized in the hold-harmless rate per visit.

A hospital that is paid interim payments at a percentage of charges for outpatient visits on June 30, 2001 does not have a hold-harmless rate per visit and is not eligible for hold-harmless status. Critical access hospitals are not covered by and are not eligible for these hold-harmless provisions.

4241 How Hold-Harmless Determined. The hold-harmless rate per visit applies if a hospital's hold-harmless rate pet visit is greater than the rate per outpatient visit including amounts resulting from administrative adjustments under §6800. The hospital is referred to as being held-harmless.

4242 When Hold-harmless Determined. The above hold-harmless determination applies for state fiscal years beginning on and after July 1, 2001. It is applied each time the rate per outpatient visit is recalculated under §4220 and whenever that rate is adjusted for administrative adjustments under §6000.

4243 No Administrative Adjustment Of Hold-Harmless Rate. A hold-harmless rate cannot be adjusted for the administrative adjustments of §6000 and §6800. Administrative adjustments can only be applied to the outpatient rate per visit from §4220. For a held-harmless hospital, an administrative adjustment to its rate per outpatient visit may be sufficient to increase its rate above its hold-harmless rate and thus lift the hospital out of hold-harmless status.

4250 Budget Neutrality Factor. A budget neutrality factor is calculated for each upcoming State fiscal year. Whether or not a hospital is held-harmless depends on the budget neutrality factor that is applied in §4220 for calculating the rate per outpatient visit. Before calculating the budget neutrality factor, the Department identifies the amount of funds that are available in the upcoming State fiscal year to reimburse hospitals for outpatient services. The Department also estimates the gross projected costs to be incurred by each and all hospitals for these outpatient services. The budget neutrality factor is the quotient of the total funding available for reimbursing hospitals divided by the projected costs of all hospitals.

According to §4220, the budget neutrality factor times the average inflated costs per visit for each hospital results in each hospital's rate per outpatient visit. A hospital gets its hold-harmless rate if its rate per outpatient visit is a lower rate. The difference, that is, the extra funding needed to reimburse hold-harmless hospitals at their higher hold-harmless rate, is taken-out of the funds available for paying the rate per outpatient visit.

Then, another calculation of the budget neutrality factor is done using the reduced available funding as the dividend and the projected hospital costs as the divisor. The resulting budget neutrality factor is applied to further decrease the rates per outpatient visit for all hospitals. Hold-harmless hospitals are again identified and available funds reduced for the extra funds needed for the hold-harmless hospitals.

This calculation of a budget neutrality factor is done over and over until there are no additional hold-harmless hospitals identified. At that time, this is the budget neutrality factor used for the calculating the rates per outpatient visit for the upcoming State fiscal year.

4300 Interim Payments.

Payments, based on an interim rate, are provided during a hospital's fiscal year. Interim payments are reconciled to reimbursable costs at the time of retroactive settlement. For most hospitals, this interim rate is the hospital's rate per outpatient visit or, if applicable, the hospital's hold-harmless rate. For new hospital providers for which an audited cost report is not available, the Department makes interim payments at the average percentage of allowed outpatient hospital charges paid to in-state hospitals. Clinical diagnostic laboratory tests performed with outpatient visits are paid at WMP fee schedule for such tests. The Department may adjust interim payment rates in order to approximate the amount that is expected to be due the provider upon final settlement. This may include, but is not limited to, administrative adjustments under §6000 and §6800.

4400 Computation of Retroactive Settlement

4410 Retroactive Settlement Period. A hospital's interim payments are reconciled to the hospital's reimbursable cost for the period of its audited cost report. Most cost reports cover the hospital's fiscal year but could cover a period other than twelve months. The period need not coincide with the State fiscal year.

4420 Allowable Outpatient Costs. A hospital's *"allowable outpatient costs"* are identified in its audited cost report and are determined according to applicable Medicaid and Medicare standards and principles of reimbursement (42 CFR Part 405 and HIM-15). The cost report provides a methodology of cost finding that identifies the amount of costs applicable to outpatient services provided persons eligible for fee-for-service coverage of the Wisconsin Medicaid program.

Computation of Retroactive Settlement, Continued

4430 Limitations On Reimbursed Costs. The amount of allowable outpatient cost that is finally reimbursed in the retroactive settlement is limited by all of the following amounts. Allowable outpatient costs that exceed any of these limitations are not reimbursed.

1. The "c*alculated gross rate amount"* is the rate per outpatient visit including amounts for administrative adjustments under §6800, or is the hold-harmless rate per visit if applicable, multiplied by the number of outpatient visits incurred by the hospital for WMP recipients in the settlement period. For a cost report period that overlaps two State fiscal years, rates and visits for each of the overlapping periods are combined. For example, given a cost report of a December end fiscal year, the January to June visits multiplied by the rate for January to June equals a gross amount. The July to December visits multiplied by the rate for those months equals a gross amount. Summing the two gross amounts gives the "calculated gross rate amount" for the cost report period.

2. The *"total allowed charges"* for the outpatient visits of WMP recipients during the cost report period are tabulated and summed from the UB-92 billing claims submitted by the hospital to the WMP. Allowed charges means charges for medically necessary services covered by the WMP.

3. A *"gross laboratory-fee-limited ceiling"* is the sum of the amounts calculated under items (a) and (b) below.
   (a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests based on the WMP fee schedule for such tests.
   (b) For other services provided in the outpatient visits (that is, services other than the above laboratory tests), the lower of the following is determined, either (1) the total allowed charges for such other services, or (2) the total costs for such other services.

4450 Determine Reimbursement Settlement. The *"reimbursable costs"* for a hospital is the lower of (1) its "calculated gross rate amount", (2) its "total allowed charges", or (3) its "gross laboratory-fee-limited ceiling", or (4) its "allowed outpatient costs".

If interim payments for the cost report period exceed "reimbursable costs", then the Department recovers the excess payments. If interim payments are less than the "reimbursable costs", then the Department is liable to the hospital for the difference.

It should be noted that the hold-harmless rate is not a guaranteed reimbursement for the final settlement. Final settlement can be at less than the hospital's hold-harmless rate.

4490 Periods in Process as of July 1, 2001. As of July 1, 2001, some hospitals are in the middle of their fiscal year for cost reporting. For these cost reports, the rate per outpatient visit and the rural adjustment in effect for the period prior to July 1, 2001, is applied to the visits for that period when determining the "calculated gross rate amount" in item 1 above.

4900 Critical Access Hospitals

4920 Interim Payments. Interim payments are made at the critical access hospital's (CAH) average inflated cost per visit of §4210 above. The Department may adjust interim payment rates to approximate the retroactive settlement. A CAH may request the administrative adjustment under §6890, "Critical Access Hospital Interim Cost Payment Adjustment".

4930 Retroactive Settlement. Critical Access Hospital's outpatient payments are subject to a retroactive settlement based on the final Medicaid cost report for the hospital's fiscal year. The final settlement will compare the lower of the hospital's allowable costs, allowable charges, or "gross laboratory-fee-limited ceiling", with the interim Medicaid payments for those services.

A "gross laboratory-fee-limited ceiling" is the sum of the amounts calculated under items (a) and (b) below.

(a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests based on the WMP fee schedule for such tests.
(b) For other services provided in the outpatient visits (that is, services other than the above laboratory tests), the lower of the following is determined, either (1) the total allowed charges for such other services, or (2) the total costs for such other services.

If the interim payments exceed the final settlement comparison for the lower of the allowable costs, allowable charges or "gross laboratory-fee-limited ceiling", the department will recover the excess payments.

If the final settlement comparison for the lower of the hospital's allowable cost, allowable charges or "gross laboratory-fee-limited ceiling" exceed the interim payments, the department will reimburse the hospital by the amount of the lower of the hospital's allowable cost, allowable charges or "gross laboratory-fee-limited ceiling, minus interim payments.

5000 REIMBURSEMENT FOR OUTPATIENT SERVICES PROVIDED OUT-OF-STATE

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, shall be paid at the average percentage of allowed outpatient hospital charges paid to in-state hospitals. Reimbursement for diagnostic laboratory services will be the lower of laboratory fee schedule amounts of the Wisconsin Medical Assistance Program or the hospital's laboratory charges for services rendered. Payment for outpatient services provided by out-of-state hospitals which are not certified as border status will be limited to emergency services or services prior authorized by the Wisconsin Medical Assistance Program.

5500 BORDER METROPOLITAN STATISTICAL AREA (MSA) SUPPLEMENT

5520 Qualifying Criteria. A hospital may qualify for a border MSA supplement payment if it is located in a metropolitan statistical area (MSA) which has its primary urban area located in a state other than Wisconsin. MSA designations to be used are those used by CMS in the Medicare program on July 1, 1993.

5530 Calculation of Payment. A monthly payment will be determined for each qualifying hospital based on the amount of outpatient services which were provided to Wisconsin Medical Assistance Program (WMAP) recipients. Total annual supplemental payments to all qualifying hospitals shall not exceed an annual target amount. A monthly payment amount will be determined according to the following formula effective May 1994 through June 1995. As of July 1995 and each July thereafter, the payment amount will be updated and effective for each 12 month period, July through June.

V	=	Number of WMAP outpatient visits in the 12 month period which begins in the month of July, two calendar years prior to the effective date of the MSA supplement update. (Example, for the May 1, 1994 effective date, the 12 month period will be July 1992 through June 1993; for a July 1, 1995 effective date, July 1993 through June 1994 will be used.)
W	=	Weighting factor from table in §5540 below
V x W	=	Weighted visits of a qualifying hospital
Sum of (V x W)	=	Sum of weighted visits of all qualifying hospital
T	=	Statewide expenditure target amount as stated in §5560 below
M	=	Monthly payment to the qualifying hospital

Calculation: [(V x W) / Sum of (V x W) x T] / 12 months = M

5540 Weighting Factor. The weighting factor (W) will be selected from the following table based on the hospital's Medicaid utilization rate for services provided during its fiscal year which ended in the calendar year ending two years prior to the effective date of the supplemental payment. (Example, for May 1, 1994, the hospital's fiscal year ending in 1992 will be used; for a July 1, 1995 effective date, the hospital's fiscal year ending in 1993 will be used.) The hospital's Medicaid utilization rate will be the hospital's total charges for WMAP covered inpatient and outpatient services divided by the hospital's total charges for all patient services provided during its fiscal year. Total charges will be based on the charges reported by the hospital in its "Fiscal Year Hospital Fiscal Survey". Charges for WMAP services will be based on Medicaid claims submitted to the WMAP and will not include charges for services which were covered in full or part by Medicare and charges for services for which the WMAP did not make a payment to the hospital (such as hospital stays for which insurance paid the full amount for which the WMAP would have paid).

Medicaid Utilization Rate	Weighting Factor
Up through 7.5%	15
7.6% through 9.9%	30
10.0% and greater	45

5560 Target Amount. The annual target amount will be $250,000.

5700 HOSPITAL OUTPATIENT EXTENDED NURSING SERVICES

Hospital outpatient extended nursing services are nursing services and respiratory care provided by nurses, for part of a day, in a group setting, on the site of an acute care general hospital approved under Wis. Admin. Code ch. HFS 124 or in a building physically connected to an acute care general hospital approved under Wis. Adm. Code ch. HFS 124. The nursing services must be administered by or under the direct on-site supervision of a registered nurse. All medical care services must be prescribed by a physician.

Prior Authorization. Hospital outpatient extended nursing services must be prior authorized by the WMAP and, if not prior authorized, will not be reimbursed. Only persons who require eight or more hours per day of nursing services as determined by the WMAP may qualify for outpatient extended nursing services. The WMAP will use its criteria for private duty nursing services to determine a person's need for nursing services. The request for prior authorization must describe the expected means by which the participant will regularly be transported between the participant's residence and the hospital.

Reimbursement. The reimbursement for outpatient extended nursing services shall cover all nursing services, accommodations and daily board provided by the hospital. The services will be reimbursed at an hourly rate. The hourly outpatient extended nursing services rate may be billed only for the time during which an outpatient extended nursing services patient is physically present at the hospital and attended by a nurse or a hospital staff person under the direct supervision of a nurse. Any portion of a quarter of an hour of presence at the hospital for outpatient extended nursing services can be charged as a full quarter of an hour.

The payment rate is the lesser of the provider's usual and customary charge per hour or the maximum hourly fee established by the Wisconsin Medicaid program for private duty nursing services provided by a registered nurse (RN) certified for respiratory care. The methods and standards for establishing the maximum fee is described in Item F, Methods and Standards for Establishing Payment Rates for Non-Institutional Care, of Attachment 4.19B of this state plan as amended by Wisconsin State Plan Amendment 96-013, effective April 1, 1996.

No Final Settlement. The reimbursement for outpatient extended nursing services will not be included in the outpatient final settlement described in section 4000.

Cost Reporting. A hospital must separately identify and report in its Title XIX cost report those direct and indirect costs attributable to the outpatient extended nursing services.

6000 ADMINISTRATIVE ADJUSTMENT ACTIONS

For Hospitals In Wisconsin Only

6100 Introduction.

The Department provides an administrative adjustment procedure through which an in-state hospital may receive prompt administrative review of its outpatient reimbursement under the circumstances described in section 6800. Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment. If the hospital disputes the staff determination, the administrative adjustment can be forwarded for review to the Administrative Adjustment Committee (AAC). The AAC provides a recommendation to the Department regarding the disputed adjustment. A detailed description of the policies and procedures for processing administrative adjustments is in the Appendix. Administrative adjustment actions are not available to out-of-state hospitals (reference §5000).

6200 Hospital's Submission of Request for Adjustment.

A hospital must deliver a written request to the Department for an administrative adjustment within the time constraints of the 60 day rule below. An adjustment may be requested for interim payment rates and for reimbursement final settlements.

In order to be considered sufficient, the hospital must specify the following items in its written request: (1) that the request applies to its outpatient reimbursement, *(2)* either the effective date of the interim payment rate or the final settlement year for which an adjustment is being requested and *(3)* the specific matter listed in §6800 below for which the hospital is making its request for an adjustment. The Department may, at its discretion, pursue clarification of and subsequently accept an incomplete request.

Requests should be addressed to the:

Bureau of Health Care Financing, Hospital Unit,
1 West Wilson Street, Room 250,
P. O. Box 309, Madison,
Wisconsin 53701-0309.
The FAX telephone number is (608) 266-1096 but may change without notice.

If a hospital had requested an adjustment to an interim payment rate, the Department will generally include the adjustment in subsequent interim rate calculations or final settlement calculations without the hospital specifically requesting the adjustment. (Adjustment §6810 below allows a hospital to withdraw such an adjustment the Department made at its discretion.) *However, it is the hospital's responsibility to assure that any administrative adjustment it wants are included in its interim rates and in its final settlement calculations.* If not included, the hospital must submit a request for the adjustment within the appropriate time limit.

6300 The 60 Day Due Date Rule.

The effective date of an administratively adjusted payment rate shall depend on when the hospital requests the adjustment or the Department initiates the adjustment. The effective date shall be established according to the following criteria.

6301 Definition, "Delivery date".

The U.S. Postal Service postmark date will be considered delivery date of a mailed administrative adjustment request. If delivered by FAX machine, the inscripted date from the Department's FAX machine shall be considered delivery date. Delivery date under any method, other than U.S. mail or FAX, shall be the day the Department receives delivery.

The Department is not responsible for written requests which are lost in transit to the Department. If lost, the hospital must demonstrate to the satisfaction of the Department that a "delivery date" had been established according to the above criteria. The Department recommends that hospitals use registered return-receipt U.S. mail in order that they have documentation of the postmark date and that the Department received the request.

6302 Interim Rates, Due Date for Request for Administrative Adjustment.

A hospital may request an adjustment to its interim payment rate. Within the 60 day period after the date of a notice of interim rate approval, a hospital must deliver a written request to the Department for an administrative adjustment in order for the requested adjustment to take effect on the original effective date of the interim rate. If a hospital delivers a written request more than 60 days after the date of a notice of interim rate approval, then any adjusted rate shall take effect on the first of the month following the delivery date. The Department's notice of the adjusted interim rate does not start a new 60 day period.

A *notice of interim rate approval* is a written notice to a hospital from the Department which lists the hospital's interim rate and its effective date and also states that the hospital has 60 days to request an administrative adjustment.

6303 Final Settlement, Due Date for Request for Administrative Adjustment.

A hospital must deliver a written request to the Department for an administrative adjustment within the 60 day period after the date of the notice of final settlement. A request will be denied if it is delivered more than 60 days after the date of the notice of final settlement. It should be noted that the rates per outpatient visit which apply to a final settlement may be administratively adjusted at the time of the final settlement.

A *notice of final settlement* is a written notice to a hospital from the Department which identifies the results of the final settlement calculation for a specified fiscal year of the hospital. It will also state that the hospital has 60 days to request an administrative adjustment.

6400 Administrative Adjustments Initiated by the Department.

The Department may initiate an administrative adjustment not requested by the hospital and incorporate the adjustment into its calculation of an interim rate or into its final settlement calculations. However, the Department may initiate an adjustment after it has sent a notice of interim rate approval or a notice of final settlement to the hospital. The date the Department initiates the adjustment is the date of any written notice the Department may provide to the hospital which notifies the hospital that the Department has initiated an administrative adjustment. If the date of that notice is within 60 days after the date of a notice of an interim rate approval or a notice of final settlement, the adjustment shall take effect on the original effective date of the interim rate or the final settlement. If more than 60 days, the adjustment shall take effect on the first of the month following the date of the Department's notice that it is initiating an adjustment. If the Department's adjustment causes a reduction of reimbursement, the hospital may request an administrative adjustment within the above 60 day rule period.

6500 Correction of Inappropriate Calculations, Coincident With An Adjustment.

The Department may find an inappropriate calculation of a hospital's interim rate or final settlement coincident with its processing an administrative adjustment. An inappropriate calculation is defined in §6820 below. The Department's correction of the inappropriate calculation will be effective the date the administrative adjustment is effective. If a requested adjustment is denied, the correction of the inappropriate calculation found by the Department will be effective the date the requested adjustment would have been effective had it been approved. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the corrected interim rate or final settlement if the correction causes a reduction of reimbursement.

For example, the adjustment requested by a hospital provided a $10 rate increase. An inappropriate calculation found by the Department caused a $2 decrease. Even though the net effect is an $8 rate increase, the isolated effect of the Department's correction caused a $2 decrease. As a result, the hospital will have a new 60 day period for requesting an administrative adjustment.

6600 Reduced Payment Possible.
If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been applied, the lesser amount will be paid. If an administrative adjustment results in an increased payment, the increase shall be paid.

6700 Withdrawal.
Once Department staff has calculated the adjustment requested by a hospital and notified the hospital of the results the hospital cannot withdraw its request for the administrative adjustment. However, adjustment §6810 below allows a hospital to withdraw an adjustment under certain circumstances at the time of final settlement. The Department cannot withdraw an administrative adjustment after it has notified the hospital that it has initiated an administrative adjustment.

6800 Criteria for Administrative Adjustments

Administrative adjustments are available for the following specific circumstances or occurrences.

6810 Withdrawal of Adjustment Under Special Case

As a general practice, the Department will include an administrative adjustment in a final settlement which the hospital had previously received in its interim rate for the settlement year. Similarly, if a hospital requested an adjustment to a previous year's interim rate, the Department may include the adjustment in a current year's interim rate without a specific request from the hospital. *However, it is the hospital's responsibility to assure that any administrative adjustment it wants are included in its interim rates and in its final settlement calculations.* If not included, the hospital must submit a request for the adjustment within the appropriate time limit.

This administrative adjustment allows the hospital to reverse such an adjustment made by the Department. The hospital may request that the adjustment be taken-out of the final settlement or an interim rate.

Request Due Date: The above 60 day rule applies (see §6300).

Adjustment Procedure: The Department will recalculate the final settlement or the interim rate at issue.

6820 Correction of Inappropriate Calculation of Interim Rate or Final Settlement

Qualifying Determination: The interim payment rate or a final settlement must have been inappropriately calculated under the rate setting plan.

(1) The application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or
(2) A clerical error in calculating the hospital's payment rate, or
(3) Incorrect or incomplete application by the Department of provisions of the reimbursement methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment.

Request Due Date: The above 60 day rule applies (see §6300). However, for corrections initiated by the Department, the Department may correct a rate retroactively effective to the rate's original effective date if the rate had been based on data which was not audited by the Wisconsin Medical Assistance Program.

Adjustment Procedure: The hospital must supply data or information to the Department to support an adjustment. The data must be able to be audited currently or at a latter time by the Department. An audited cost report of the hospital may need to be reopened in order to resolve the adjustment request.

Reopening Cost Report: Either the hospital or the Department may request that the Medicaid audit contractor reopen an audited cost report in order to correct an error in the data on which an interim rate was based or on which a final settlement was based. The administrative adjustment request for the correction of an interim rate or a final settlement which requires the reopening of an audited cost report must be delivered within the time limit of the above 60 day rule.

> For example, the base year of a new provider, ABC Hospital, is its fiscal year ending December 1991. On July 12, 1994 it received a notice of final settlement for its fiscal year ending December 1992. It immediately submitted an administrative adjustment request to reopen its 1991 audited cost report in order to correct data on which its rate per outpatient visit was calculated. The 1991 cost report was reopened, the outpatient rate per visit corrected and its 1992 final settlement corrected. ABC Hospital also requested its final settlement for 1991, which had been completed a year earlier, be corrected. That administrative adjustment request was denied because it had not been submitted within 60 days of the 1991 settlement (i.e., the time limits of the 60 day rule).

An audited cost report may be reopened only if all of the following conditions are satisfied: (1) the dollar effect is $5,000 or greater, (2) the statistic affecting the payment rate is in error by 5% or more, and (3) the request for reopening and the necessary data is submitted to the audit contractor within five years from the end date of the reporting period for which the cost report is being reopened. The audit contractor will apply these conditions.

The Department may request that the audit contractor obtain additional data or perform additional audit tests when reopening a cost report. The audit contractor's charge to the Department for reopening a cost report may be billed to the provider if it was the provider's error that was in need of correction.

Legal Review Pursued by Hospital: Corrections of payment rate calculations must be pursued by a hospital through this administrative adjustment before the hospital can pursue legal review of its rate calculation. If a hospital does pursue any available legal review after requesting an administrative adjustment, the Department will withdraw any proposed rate adjustment it has offered to the hospital as to any given issue, and the Department will not put the adjusted payment into effect. If the adjusted payment has been put into effect and it is an increase over the payment previously in effect, the adjusted payment will be retroactively rescinded to the date it had been made effective and replaced with the payment in effect prior to the adjustment. In such a case, increased payments at the adjusted rate will be recovered by the Department.

6830 Case-Mix Adjustment

A case-mix adjustment is an adjustment to the “rate per outpatient visit” (as determined according to §4200) that provides for changes in the mix of services from the outpatient base year to the final settlement year. As of July 1, 2001, a critical access hospital can have its “average inflated Cost per visit” adjusted in the same manner as described herein for the “rate per outpatient visit”.

Request Due Date: The above 60 day rule applies (see §6300). The Department may provide up to a 30 day extension of the request due date if the hospital delivers a written request for the extension within the period of the 60 day rule. It should be noted that if a case-mix adjustment is requested and the Department calculates a decrease in the rate per outpatient visit, the Department will pay at the reduced rate. The purpose for providing for an extension is to allow a hospital adequate time to gather the necessary data to make an informed decision as to whether or not it wants to request a case-mix adjustment. The hospital may request from the Department a tabulation of its charges to the Wisconsin Medical Assistance Program (WMAP).

Adjustment to Interim Rate: The Department may provide an interim case-mix adjustment to the rate per outpatient visit which was determined under §4200. Upon consultation with the Department, the hospital must provide the Department sufficient information in order that a reasonable and reliable estimate of the case-mix adjustment for the final settlement year can be calculated by the Department.

Final Settlement Adjustment: The case-mix adjustment will be calculated for the full final settlement year according to the methodology described on the next page.

Case-Mix Adjustment, Continued

	CALCULATION FOR CASE MIX ADJUSTMENT	RESULT
1	For the outpatient base year, total direct cost from Schedule B of the cost report for each revenue producing cost center (i.e., service area) divided by the total charges for each cost center.	Ratio of direct cost -to- charges for each cost center.
2	Result 1 for a cost center multiplied by T-19 outpatient charges (i.e., charges to WMAP) for the respective cost center.	Gross T-19 base year direct costs for each cost center.
3	Result 2 for a service area divided by number of T-19 services for base year for the service area.	T-19 base year cost per unit of service in each service area
4	For the settlement year, number of T-19 services performed in a service area divided by total T-19 services for the year in all service areas.	Percentage of T-19 services in each service area in settlement year
5	Result 4 for a service area multiplied by total number of T-19 services performed in all service areas in the base year.	Adjusted number of base year T-19 services for each service area
6	Result 3 multiplied by Result 5 for each respective service area.	Adjusted base year T-19 direct cost for each service area.
7	Sum of Result 6 for all service areas minus the sum of Result 2 for all service areas.	Gross increase or decrease in direct cost.
8	Result 7 divided by total number of T-19 services performed in base year.	Increase or decrease in direct cost per service or visit.
9	Prior to July 1, 2001, Result 8 multiplied by 1.00 plus the applicable base year cost adjustment factor from §4200. As of July 1, 2001, Result 8 is adjusted by the inflation adjustment multiplier used under §4210 and also is multiplied by the budget neutrality factor used under §4220.	Increase or decrease adjusted to final settlement year.
10	Result 9 plus the rate per outpatient visit for final settlement year as determined per §4200..	Rate per outpatient visit for final settlement year, adjusted for case-mix.

6840 Adjustment for Major Capitalized Expenditures

For Final Settlement Years Ending On and After November 1, 1993

This administrative adjustment provides for an updating of the capital cost component of a hospital's "rate per outpatient visit". It provides a means through which a hospital can have its rate per outpatient visit adjusted to recognize current major expenditures which improve, add to, or replace existing equipment and structures which are directly or indirectly used for outpatient services. The following criteria apply to adjustments of the rate per outpatient visit for any final settlement year which ends on and after November 1, 1993.

As of July 1, 2001, a critical access hospital can have its "average inflated cost per visit" adjusted in the same manner as described herein for the "rate per outpatient visit".

Qualifying Determination: The hospital's total capitalized depreciable assets at the end of the hospital's final settlement year have increased by an amount which is 25% of total capitalized depreciable assets at the beginning of the outpatient base year. Qualification shall be determined by comparing the amount of capitalized depreciable assets reported in the hospital's audited financial statements for the hospital's final settlement year and its outpatient base year.

(Continued on next page, page 10)

Request Due Date: The above 60 day rule applies (see §6300). However, for interim rates effective November 1, 1993, a request for an adjustment may be delivered by March 15, 1994 in order for the adjustment to be retroactive to November 1, 1993.

Definition. Capitalized depreciable assets include depreciable land improvements, buildings, fixed equipment and moveable equipment which are owned by the hospital and such assets leased by the hospital through capitalized leases and excludes capitalized construction-in-progress.

Definition. The *audited financial statements* of the hospital are its independently audited financial statements with a statement of audit scope and opinion by a certified public accountant.

Adjustment of Interim Rate: The Department may provide a capital adjustment to the interim rate which was determined under §4200. Upon consultation with the Department, the hospital must provide sufficient information in order that reasonable and reliable estimates can be made by the Department. The Department will estimate if the hospital will likely qualify for an adjustment to the rate per outpatient visit upon final settlement. If it is estimated that the hospital will likely qualify, then an estimate of the final expected capital payment can be included in the interim payment rate.

Final Settlement Adjustment: Final determination of whether or not the hospital qualifies for the adjustment will be made at the time of the final settlement calculation for the final settlement year in which the adjustment is to be allowed. If the hospital qualifies, the rates per outpatient visit for the final settlement year will be adjusted to consider the major increase in capitalized expenditures.

An updated capital cost component will be added to and the base year capital cost component subtracted from the rates per outpatient visit which had been established for the final settlement year according to §4200.. The results are the adjusted rates per outpatient visit.

An *updated capital cost component* of the rates per outpatient visit will be determined for the settlement year based on cost information from the audited Medicaid cost report for the final settlement year. The hospital's allowed outpatient costs attributed to WMAP recipients will be multiplied by the ratio of total allowed hospital capital costs to total allowed hospital costs. The resulting gross amount will be divided by WMAP recipient outpatient visits for the final settlement year. Prior to July 1, 2001, the result is the updated capital cost component which will be reduced by the capital reduction factor of §4200 for dates of service on and after July 1, 1992 and prior to July 1, 2001. As of July 1, 2001, the resulting per visit amount is multiplied by the budget neutrality factor in lieu of a capital reduction factor.

The *base year capital cost component*, determined under §4200 will be calculated as follows. The hospital's allowed outpatient costs attributed to WMAP recipients for the outpatient base year will be multiplied by the ratio of total allowed hospital capital costs to total allowed hospital costs for the outpatient base year. Prior to July 1, 2001, the resulting gross amount will be divided by WMAP recipient outpatient visits for the outpatient base year and then increased by the applicable base year cost adjustment factor of section §4200. The result is the base year capital cost component which will be reduced by the capital reduction factor of §4200 for dates of service on and after July 1, 1992 and prior to July 1, 2001. As of July 1, 2001, the resulting gross amount will be divided by WMP recipient outpatient visits for the outpatient base cost reporting period and then adjusted by the inflation adjustment multiplier used in §4210 and multiplied by the budget neutrality factor used in §4220.

6842 Major New Construction Project

For Final Settlement Years Ending Before November 1, 1993

A hospital, which has had a major new construction project for which the related capital expenses are not included in the cost report for the outpatient base year, may request an adjustment to its rate per outpatient visit.

(Continued next page, page 11)

In order to qualify for an administrative adjustment, the capital expenditure must be a single, identifiable construction or renovation project that was undertaken, and not an agglomeration of small or unrelated construction projects. A major construction project involves a one-time capital expenditure exceeding 25% of the cost to construct the entire original facility and must be designed to improve or add to or replace an existing patient-care structure. The hospital requesting this adjustment must furnish audited financial statements or a certified statement by a CPA firm which identifies the hospital's depreciation, leases, capital-related interest, and total hospital costs for the fiscal periods to be specified by the Department.

A new capital cost component of the rate per outpatient visit will be determined which includes recognition of the major construction project. Cost information from the audited cost report specified by the Department shall be used for this calculation. The capital cost attributable to WMAP (Wisconsin Medical Assistance Program) recipient outpatient services shall be determined by multiplying the hospital's allowed outpatient cost attributable to WMAP recipient outpatients by the ratio of total allowed hospital capital costs to total allowed hospital costs. The resulting gross amount shall be divided by WMAP recipient outpatient visits for the cost report period. The Department shall index this new capital cost per WMAP outpatient visit by the DRI/McGraw Hill, Inc. Hospital Market Basket Index. The result is the new capital cost component which shall be included in and replace the prior capital cost component of the hospital's rate per outpatient visit.

The prior capital cost component of the hospital's rate per outpatient visit shall be subtracted from the hospital's rate per outpatient visit. Cost information from the audited cost report used to calculate the rate per outpatient visit shall be used. The capital cost attributable to WMAP recipient outpatient services shall be determined by multiplying the hospital's allowed outpatient cost attributable to WMAP recipient outpatients by the ratio of total allowed hospital capital cost to total allowed hospital costs. The resulting gross amount shall be divided by WMAP recipient outpatient visits for the cost report period. This prior capital cost component per WMAP outpatient visit shall be subtracted from the hospital's rate per outpatient visit.

6850 Adjustment to Rural Outpatient Adjustment Percentage for Recognition of Out-of-State Medicaid Services For Rates per Outpatient Visit <u>prior to July 1, 2001</u>

Qualifying Determination. This adjustment allows a hospital, which provides services covered by a Medicaid program of a state other than the Wisconsin Medical Assistance Program (out-of-state Medicaid), to have those out-of-state Medicaid services recognized in determining its eligibility for the rural hospital adjustment and amount of its adjustment in calculating its rate per outpatient visit in effect prior to July 1, 2001.

Request Due Date : The above 60 day rule applies (see §6300). However, for interim rates effective November 1, 1993, a request for an adjustment may be delivered by March 15, 1994 in order for the adjustment to be retroactive to November 1, 1993.

Adjustment Procedure: The hospital will need to report charges for inpatient and outpatient services provided during its fiscal year which ended in 1992 which were paid (or payable) by out-of-state Medicaid programs. These charges will be included in the calculation of the rural hospital adjustment under §4300 that applied prior to July 1, 2001. The data may be audited at a latter date and, if the data is found to be in error, the Department will recover any overpayment that result from the erroneous data.

6851 New Base-Year for Combining Hospital Affected by Section 4840

For Rates per Outpatient Visit and Final Settlements On and After July 1, 1995 And Prior to July 1, 2001

Background: Hospitals that combine into one operation with one Wisconsin Medicaid provider number on or after July 1, 1995 and prior to July 1, 2001, either through merger or consolidation or a hospital absorbing the operation of another hospital through purchase or donation, receive a base outpatient rate-per-visit according to section 4840 that applied prior to July 1, 2001. This rate is a mix of the base rates-per-visit of the previous individual hospitals as calculated from each individual hospital's base-year cost report. However, if the newly combined hospital requests a case-mix adjustment under section 6830, it may not be possible to calculate. A reliable case-mix adjustment requires a consistent unit of service between the outpatient base-year and the final settlement year. The units by which the combined hospital counts or measures the services it provides may not be comparable to the units used by the previous individual hospitals. (For example, in one hospital a unit of an item may be in ounces. In the other hospital, it may be in liters.) It is very unlikely that the base-years (as defined in section 3000 prior to July 1, 2001) of the previous individual hospitals can be case-mix adjusted to the combined hospital's settlement fiscal year.

Qualifying Criteria: A hospital that receives a combined average base rate-per-visit under section 4840 prior to July 1, 2001, may request a new base-year on which to establish a new rate-per-visit. The new base-year will be the hospital's first full fiscal year that begins on or after six months after the effective date of the hospital merger, consolidation or absorption. This adjustment is available to a qualifying hospital for services provided on and after January 1, 1996 and prior to July 1, 2001.

Request Due Date for This Section 6851: The 60-day rule of section 6300 applies but requests delivered by June 30, 1996 may be effective January 1, 1996.

Interim Adjustment: The Department may provide an interim adjusted rate-per-visit until the final adjustment described below can be completed. Upon consultation with the Department, the hospital must provide sufficient information so the Department can establish an interim adjustment that will approximate the final adjustment.

Final Adjustment Procedure: A new base rate-per-visit will be calculated when the audited Medicaid cost report is available for the new base-year. The new base-year will be the combined hospital's first full fiscal year that begins on or after six months from the effective date of the hospital merger, consolidation, or absorption.

1. The audited cost, which is attributed to outpatient services provided Medicaid recipients, will be identified.
2. The costs from step 1 will be reduced for the cost of services attributable to laboratory services reimbursed under the laboratory fee schedule of the Wisconsin Medicaid program. These are services covered by the clinical laboratory reimbursement defined in section 3000 prior to July 1, 2001.
3. The remaining costs from step 2, after excluding the laboratory costs, will be deflated to the base-year described in section 3000 prior to Juy 1, 2001, by applying the appropriate DRI/McGraw Hill, Inc. hospital market basket index.
4. The result from step 3 will be increased by the adjustment factors listed in item 3 of section 4200 to the final settlement year. (The final settlement year is described in section 3000 prior to July 1, 2001.)
5. The clinical diagnostic laboratory reimbursement for laboratory services provided in the new base-year will be added to the adjusted amount from step 4.
6. The sum from step 5 will be divided by the number of outpatient visits of Medicaid program recipients in the new base-year. This is the new rate-per-visit for outpatient services.

For settlement years following the above new base-year, the hospital can request a case mix adjustment under section 6830. The above new base-year will be the base-year for use in a case-mix adjustment.

An Example Case:

On March 10, 1996, Hospital-A combines with Hospital-B resulting in a combined hospital, Hospital-C. Hospital-C has December ending fiscal years. The outpatient rates per visit of Hospital-A and Hospital-B are averaged together according to §4840 to be Hospital-C's rate-per-visit effective March 10, 1996.

In April 1999, Hospital-C's audited 1996 cost report is available and a settlement is calculated for the fiscal year. The Department notifies the hospital of the results. Within 60 days of the notification, the hospital requests a new base-year under the administrative adjustment of §6851. The new base-year will be its fiscal year January through December 1997, which is its first fiscal year that began on or after six months from the date of the hospitals combining, that is, March 10, 1996.

In June 2000, Hospital-C's audited 1997 fiscal year cost report is available. An outpatient rate-per-visit is calculated from that cost report according to the adjustment procedure described above. Given the new base-year rate-per-visit, the settlements for Hospital-C's 1996 and 1997 fiscal years are completed.

It should be noted that Hospital-C waited until its settlement to request the above administrative adjustment for a new base-year. The hospital could have requested the adjustment earlier and received an interim adjusted rate-per-visit. As done in the example, a final base rate-per-visit would have been calculated when its 1997 audited cost report (its new base-year) became available.

6860 Combining Two Settlement Years, Only for Settlement Years Ending Between July 1993 and June 1995

This adjustment only applies to final settlements calculated after November 1, 1993.

Qualifying Determination: This adjustment is available to a hospital if (1) the first settlement year of the hospital which ends after June 30, 1993 results in a final settlement that is limited by the rates per outpatient visit as determined under §4200 (i.e., limited by item 2 of §4100) and, (2) if for the subsequent final settlement year the allowable audited cost of outpatient services recipients is reimbursed (i.e., not limited by items 1, 2 and 3 of §4100).

Request Due Date: The hospital may request this adjustment only after completion of the second or 'subsequent' final settlement year described above. The above 60 day rule applies to the request (see §6300). No interim adjustment to the outpatient rate per visit is available.

Adjustment Procedure: The final settlement calculations for the two settlement years described above will be combined into one final settlement calculation.

6890 Critical Access Hospital Interim Cost Payment Adjustment

This administrative adjustment provides for an interim cost payment for outpatient services to critical access hospitals. Under this provision, critical access hospitals may request an adjustment to be paid allowable costs for outpatient services.

Qualifying Determination: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by HCFA, and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

Interim Cost Payment Adjustment: The Department may provide an interim cost payment until a final cost settlement can be calculated. The interim cost payment adjustment will be established based on a hospital's most recent audited cost report. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final settlement. If the information provided by the hospital to the Department is not sufficient to provide a reasonable estimate of the final settlement, no adjustment will be made until sufficient data is available or when the final settlement can be completed, whichever comes first.

State statute requires that payments, including critical access hospital reimbursement, be limited to cost.

The cost of air, water and land ambulance service are not reimbursable as outpatient hospital services for outpatient critical access hospital providers. These services must be billed by a Wisconsin Medicaid certified ambulance provider.

SECTION 7000
FUNDING OF OUTPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS

7001 GENERAL INTRODUCTION

A hospital operated by the State or a local government in Wisconsin may receive reimbursement from the Wisconsin Medicaid program for the portion of a total operating deficit that is attributable to providing outpatient hospital services to Wisconsin Medicaid recipients. This is referred to as the deficit reduction payment in this section. The amount paid to the hospital will be the federal Medicaid financing share of the deficit to the extent the governmental unit has provided sufficient funding to serve as the non-federal match. This section describes the criteria to qualify and how the reimbursement amount will be calculated. This reimbursement is available for hospital fiscal years beginning on and after January 1, 1996 and will be determined at the time the final settlement is calculated under §4000. An interim payment is available according to §7080 below. In case of federal disallowance of any amount paid to hospitals under this section, the Wisconsin Medicaid program will recoup the disallowed FFP monies from the hospitals.

7010 QUALIFYING CRITERIA

A hospital will qualify for a deficit reduction payment if:

(a) the hospital is operated by the State or a local government in Wisconsin,
(c) it incurred a deficit from providing Medicaid outpatient services (described in §7020 below),
(b) it incurred a total hospital operating deficit (described in §7030 below), and
(b) the governmental unit that operates the hospital provided funds to serve as match for the federal financial participation (FFP) (described in §7050 below) .

7020 DEFICIT FROM PROVIDING MEDICAID OUTPATIENT SERVICES

The deficit from providing outpatient services to Wisconsin Medicaid recipients (that is, the Medicaid deficit) is the amount by which cost, reduced for excess laboratory cost, exceeds the payment for the Medicaid outpatient hospital services. Excess laboratory cost is the amount by which the costs of laboratory procedures exceed the clinical diagnostic laboratory reimbursement for those procedures. Clinical diagnostic laboratory reimbursement is the lower of laboratory fee schedule amounts of the Medicaid program or the hospital's charges for the procedures (as defined in §3000). The cost of Medicaid outpatient services is identified from the hospital's audited cost report for the final settlement year. Total payment is the total of the reimbursement provided under §4000 through §6000 herein for outpatient services.

7030 TOTAL OPERATING-DEFICIT

A hospital's total operating-deficit (or profit) will be identified from the hospital's financial statements for the settlement year. The deficit or profit will be adjusted to take-out deficit reduction payments which were recognized as revenue in the financial statements. (It should be noted that payments made by the Wisconsin Medicaid program for which the governmental unit provided the matching funds may have been recognized as revenue in those financial statements and should be excluded to establish the appropriate deficit amount for use in calculating reimbursement under this section.)

7040 DETERMINATION OF REIMBURSEMENT AMOUNT

A hospital qualifies for a deficit reduction payment that is equivalent to the federal financing portion (FFP) of either its Medicaid deficit or its total operating deficit, whichever is the lesser deficit amount. The non-federal portion of the deficit amount must be funded by the governmental unit that operates the hospital. If necessary, the deficit reduction payment will be reduced to assure that the funding provided by the governmental unit equals the funding proportion (that is, the matching rate) required of State or local governments by §1902(a) of the federal Social Security Act.

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7050 FUNDING OF THE NON-FEDERAL PORTION

The governmental unit's funding of the non-federal portion must be provided by public funds that are not federal funds or, if federal funds, are federal funds authorized by federal law to be used to match other federal funds. As required by federal regulations at 42 CFR §433.51, the governmental unit which operates the hospital must certify that the amount of funding provided by the governmental unit are expenditures eligible for FFP.

7060 LIMITATION TO CHARGES

The combined total of: (a) the deficit reduction payment made by the Wisconsin Medicaid program, (b) the non-Federal portion of that payment provided by the governmental unit and (c) all other payments to the hospital for outpatient Medicaid services will not exceed the hospital's total charges for the services for the settlement year. If necessary, the deficit reduction payment will be reduced so the combined total payments do not exceed charges.

7070 AGGREGATE LIMITS ON DEFICIT REDUCTION PAYMENT

The deficit reduction payments to all qualifying hospitals will be proportionally reduced based on the total of such payments if such a reduction is necessary so that payments to all hospital combined do not exceed the aggregate limits.

The aggregate deficit reduction payments made to hospitals for outpatient Medicaid services, during any twelve-month period of July through June will not exceed the amount $3,300,000 reduced for deficit reduction payments made for inpatient services (under state plan attachment 4.19A).

The aggregate deficit reduction payments made to hospitals under this section will not exceed the amount for which FFP is available under federal upper-payment limits at 42 CFR §447.321.

7080 INTERIM PAYMENTS PENDING THE OUTPATIENT FINAL SETTLEMENT

Deficit reduction payments are available for hospital fiscal years beginning on and after January 1, 1996 and will be determined at the time the final settlement is calculated under §4000. A hospital's final settlement is not calculated until an audited cost report is available for the hospital's fiscal year. This may be two to three years after the fiscal year ends. Because of this delay, hospitals operated by the State or a local government in Wisconsin may apply for interim deficit reduction payments after completion of their fiscal years. The Department will ask applying hospitals to provide financial information so that an interim payment amount can be determined in the same manner as is described above. As described in §7040 and §7050 above, the non-federal portion of any deficit amount must be funded by the governmental unit that operates the hospital and the governmental unit must certify that the amount of funding provided are expenditures eligible for FFP.

7090 HOSPITAL MUST REQUEST FUNDING

A hospital must apply to the Department for deficit funding under this section 7000. This requirement applies to final settlements calculated after July 1, 1998 for fiscal years beginning on or after January 1, 1996.

If Interim Funding Was Provided. If the hospital applied for and received interim deficit reduction funding under §7080 for the final settlement year, then the Department will proceed with determining deficit reduction funding at the time of calculating a final settlement.

If No Interim Funding Was Provided. If no interim funding was provided under §7080 for a hospital's final settlement fiscal year, the hospital must submit a written request for deficit funding. The "60 day rule" and the due date requirements for admin-istrative adjustments, specifically §6301 and §6303, apply for this request. The request must specify the fiscal year for which the hospital wants deficit funding. The Department will determine if a hospital qualifies for deficit funding.

APPENDIX
EXAMPLE CALCULATION OF
RATE PER OUTPATIENT VISIT
And
HOLD-HARMLESS RATE DETERMINATION

Period of Hospital's Base Year Cost Report		7/1/97 to 6/30/98
1	Outpatient costs for WMP fee-for-service covered recipients (From Cost Report, Title XIX Schedule E-3)	$ 237,433
2	Times: Inflation adjustment multiplier	1.13
3	= Inflated cost report cost	$ 268,299
4	Divide by: Outpatient visits	2,012
5	= Average inflated cost per visit	$ 133.35
6	Times: Budget neutrality factor	.70
7	= Rate per outpatient visit	$ 93.34
8	The above rate per outpatient visit is compared to the hospital's hold-harmless rate.	
9	Hold-harmless rate per visit	$ 92.00
10	The higher rate applies. In this case it is the hospital's Rate Per Outpatient Visit	$ 93.34

APPENDIX

PROCEDURES FOR PROCESSING ADMINISTRATIVE ADJUSTMENTS

For Inpatient and Outpatient Hospital Payments

The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive a prompt review of their payment rates for specific circumstances. The policies and criteria for administrative adjustments that apply to hospitals are provided in the following State Plan sections:

(1) For inpatient rates for hospitals in Wisconsin and major border status hospitals, see §11000 of the "Inpatient Hospital State Plan",
(2) For inpatient rates for minor border status hospitals and out-of-state hospitals, see §10400 of the "Inpatient Hospital State Plan",
(3) For outpatient rates, see §6000 of the "Outpatient Hospital State Plan".

This appendix outlines the procedures the Hospital Unit staff of the Bureau of Health Care Financing (we) will follow for processing administrative adjustment requests from hospitals. Under some circumstances, an interim administrative adjustment may be provided with a final adjustment calculated after the a required audited cost report is available. The procedures in this appendix apply to the calculation of interim and final administrative adjustments.

These procedures apply to any administrative adjustment request submitted by a hospital on and after July 1, 1996

28010 Receipt of Request For Administrative Adjustment

A request for an administrative adjustment must meet the following requirements:

(1) *The request must be submitted by the due date.* A due date is specified in the state plan sections listed above for each circumstance for which an adjustment may be requested.

(2) *The request must be sufficient*. The request must inform us:
   (a) as to whether the request applies to inpatient or outpatient rates,
   (b) the specific circumstance listed in the state plan for which the hospital is requesting an adjustment, and
   (c) the effective date of the rate to be adjusted or the outpatient final settlement period to be adjusted.

Upon receipt of a request for an administrative adjustment, we will review the request and, if necessary, contact the hospital regarding the following items:

(1) We will determine if the request was submitted by the due date. If not, we will notify the hospital either:
   (a) if the request is denied because it has not been submitted by the required due date, or
   (b) if "the 60 day rule" allows the adjustment to be effective at some date other than the effective date of the rate for which an adjustment is being requested. (The "60 day rule" is described in §11600 of the "Inpatient Hospital State Plan" and §6300 of the"Outpatient Hospital State Plan".)

(2) We will determine if the request is sufficiently clear. If not, we will contact the hospital for clarification and may ask the hospital to resubmit a sufficient request.

(3) We will assess the data needed to calculate the adjustment. If additional data is needed from the hospital, we will request additional data according to the procedure described in §28020 below.

28020 Request For Additional Data

If we determine additional data is needed for the adjustment, we will contact the hospital to request the additional data and specify a due date for the hospital to submit it. The due date we specify will not be less than one month and not more than three months from the date of our request. However, if the hospital requests an extension and can justify that additional time is needed to provide accurate information, we may allow additional time for submitting the data.

If the hospital does not submit the data or an extension request within the specified time period, we will notify the hospital in writing that the administrative adjustment will be denied unless the hospital submits the requested data. With this notice, we will specify another due date for submitting the data of not less than two weeks and not more than one month from the date of this notice.

In order to calculate the administrative adjustment, we may find it necessary to request additional data more than once from the hospital. Each request for additional data will be handled as outlined above.

28030 Notification to the Hospital of Our Proposed Adjustment

After we have the needed data, we will calculate the adjustment and send a notification to the hospital of our proposed adjustment along with supporting worksheets.

We will request the hospital to review our proposed adjustment and respond with acceptance of the proposed adjustment or disagreements with the calculations. We will specify a due date for a response of not less than one month and not more than three months from the date of our notification to the hospital of the proposed adjustment.

If we do not receive a response from the hospital by the due date, we will notify the hospital in writing that the administrative adjustment will be finalized and approved according to the calculations we sent to them. With the notice we will specify another date by which the hospital must respond with a disagreement before we will finalize the adjustment. The date will not be less than two weeks and not more than one month from the date of this notice.

If the hospital responds with an acceptance of the proposed adjustment, we will adjust the hospital's payment accordingly.

If the hospital responds with a disagreement to our calculations, we will attempt to settle the disagreement with the hospital as described in §28040 below.

28040 If Hospital Disagrees With Out Proposed Administrative Adjustment

If the hospital disagrees with our proposed administrative adjustment, we will attempt to settle any disputes the hospital may have and reach an agreement. The process of settling disputes may continue until a mutual agreement is reached. It may involve our revising the adjustment one or more times. In the process of settling disputes, we may request additional data according to the procedures outlined in §28020 above.

28041 If We Do Not Revise the Disputed Adjustment.

If we do not revise the disputed adjustment, we will notify the hospital that no change will be made to the previously proposed adjustment. In this notification, we will inform the hospital that they can request a meeting with the administrative adjustment review panel and that such a request must be submitted by a due date that we will specify. (The panel is described in §28050 below.) The specified due date will not be less than one month and not more than three months from the date of this notice.

If we do not receive a request for a meeting from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

If the hospital requests a meeting with the review panel, we will contact the hospital to schedule a meeting.

We will not schedule a meeting with the administrative adjustment review panel until the hospital and us have attempted to reach an agreement on a disputed adjustment. We will schedule a meeting at the hospital's request only after the hospital has submitted a disagreement to our initial or first adjustment proposal and: (a) we have either responded to the hospital with at least one revised adjustment which they do not accept, or (b) we have notified the hospital that we will not change the proposed adjustment.

28042 If We Revise a Disputed Adjustment.

If we revise a disputed adjustment, we will send our revised adjustment and supporting worksheets to the hospital. With our proposing a revised adjustment, the procedures described in §28030 and §28040 above will be used for notifying the hospital and handling any disputes the hospital may have with the revision.

28050 Administrative Adjustment Review Panel

The administrative adjustment review panel serves as an advisory group to the director of the Bureau of Health Care Financing (BHCF) for final decisions on disputed administrative adjustments. The panel will be chaired by a designee of the director and will consist of at least four other staff of the BHCF. Panel members will be appointed by the director or his/her designee and will not necessarily be the same persons for each meeting or case. Up to two staff persons who are directly involved in hospital rate setting may be, but need not be, on the review panel. The staff person or persons who calculated the adjustment will not be on the review panel.

Meetings of the review panel will be scheduled with hospital consultation. The hospital's representatives may attend the meeting in person or may meet with the panel through a teleconference. In addition to meeting with the panel, the hospital's representatives may provide written position papers and other information regarding their case.

The meeting will be an informal fact finding meeting under the control and direction of the chairperson of the review panel. The BHCF staff person(s) who calculated the adjustment will explain their calculations and policy considerations and answer inquires from the panel and from the hospital's representatives. The hospital's representatives will be given the opportunity to present the hospital's case and answer inquires from the panel members and from the BHCF staff person(s) who calculated the adjustment. After hearing the presentations, the review panel will develop a recommendation for the director of the BHCF that may include or be based on a revised calculation prepared at the direction of the panel. The panel may discuss the case without the presence of the hospital's representatives.

The BHCF director or his/her designee will make the final decision on the adjustment and will send notice of the decision to the hospital.

End of Administrative Adjustment Procedures.